Medi-Cal Update- July 2011

Continuity of Care for Seniors and Persons with Disabilities (SPD)

A key element of California's "Bridge to Reform" 1115 Medicaid Demonstration Waiver, approved by the Centers for Medicare and Medicaid Services on November 2, 2010, is to provide SPD beneficiaries with access to care that is organized and coordinated as they transition into mandatory managed care starting June 1, 2011. State legislation that implemented the 1115 Waiver and the Special Terms and Conditions ensure continuity of care by requiring health plans to allow SPD beneficiaries to continue receiving treatment with their current fee-for-service (FFS) provider, even if they are not part of any managed care health plan network, to ensure continuity of care.

To ease the transition into mandatory managed care and help ensure continuity of care, the Department of Health Care Services (DHCS) requires health plans to provide a newly enrolled SPD, the opportunity to request continued access to an out-of-network provider for up to 12 months. Out-of-network provider access applies to professional services such as physicians, surgeons, and specialists, but does not apply to durable medical equipment, transportation, or other ancillary services. It also does not include carved out services such as specialty mental health. SPD beneficiaries will continue to access carved out services through FFS Medi-Cal.

For continuity of care purposes, a beneficiary's current FFS provider is not required to join a health plan network during the 12-month transition period. However, any provider who would like to continue treating these SPD beneficiaries is encouraged to work with the health plans to join their network. Providers already in a health plan network are asked to inform their patients which plan(s) they contract with, and to encourage their patients to join a health plan where they can continue seeing you.

To receive out-of-network access, a beneficiary must have an ongoing relationship with a FFS provider, the provider must be willing to accept either the health plan or Medi-Cal FFS rates, whichever is higher, and the health plan must determine that there are no quality of care issues with the provider. An ongoing relationship shall be determined by the health plan identifying a link between a newly enrolled SPD beneficiary and an out-of-network provider using FFS utilization data provided by DHCS.

If you have any SPD beneficiaries who need or want to continue to see you for continuity of care purposes, please instruct them to contact their health plan to initiate the continuity of care process. If you have any questions or need additional information on the SPD transition please access the SPD website at http://dhcs.ca.gov/SPDinfo.

If a particular SPD beneficiary has been referred to you, an appointment has been made, and there is a medical reason for keeping that appointment (e.g., a surgery that is already scheduled), the beneficiary may be able to continue to see you as an out-of-network provider for the purposes of the scheduled treatment, even if the newly-enrolled

beneficiary has never seen you before. Please instruct the beneficiary to contact the health plan for more information.

If you believe that a beneficiary you are providing services to is in need of a temporary exemption from managed care, please work with them to process a Medical Exemption Request (MER). Information on what conditions are eligible for a MER and the process can be found by calling Health Care Options (HCO) at **1-800-430-4263** or by visiting their website at:
http://www.healthcareoptions.dhcs.ca.gov/HCOCSP/Enrollment/Exception_to_Plan_Enrollment_Forms.aspx

Certain beneficiaries are also excluded from mandatory managed care. Beneficiaries that will remain voluntary for purposes of managed care include:

- Dual Eligibles, or those with Medicare
- Foster Children
- Those identified as receiving Long Term Care (LTC)
- Those with Other Health Insurance
- Those with Share of Cost (SOC) Medi-Cal
- Those receiving California Children's Services (CCS) - Although currently excluded, CCS may become mandatory in the future.

If you know of a beneficiary who fits in one of the excluded categories above and who received a notice in error requiring him/her to enroll in mandatory managed care, please advise the beneficiary to contact HCO at the number above.